JULIA BARRIGA MD PA
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INSURANCE INFORMATION

9-2-19

Financial Guarantor

(This is the person that will receive Billing Statements in the mail. Parents must agree on this and work arrangements out among themselves for payment issues)

Financial Guarantor's Full Name____ Relationship to patient: ______________________

Financial Guarantor's DOB:___________________ Financial Guarantor's Social Security #_____________________ Phone______________

Financial Guarantor's Address ____.

Do you live with patient? ___Yes ___No, ___I have read, understood and agree to the above financial policy for payment of dues.

Financial Guarantor's Signature____ Today's Date _______________

List below only children in family that the below information applies to

(If children have a different family dynamic than below - they must be on a different sheet)

	First Child	Second Child	Third Child	Fourth Child
Patient's Name as it appears on Insurance Card				
Insurance Carrier Name				
Subscriber ID				
Relationship to Subscriber	__ Self ___ Child	__ Self ___ Child	__ Self ___ Child	__ Self ___ Child
Group Number				
Group Name				
Insurance Carrier Address				
Insurance Carrier Telephone				
Primary Care Doctor listed on Card				

Insurance Card Must be present to be scanned

For Commercial Insurance Carriers: please fill out information of the Primary Subscriber (mom, dad or guardian)

Subscriber last name: _________________________________ Subscriber first name: _____________________________________

Sex: ________ Date of Birth: ________________________ Patient Relation to subscriber: ________________________________

Insurance Carrier: ____________________________________ Subscriber ID: ____

Group Number: _________________________________ Group Name: ____

Employer Name:____

Patient responsibility (If you do not know, leave it blank): PCP visit copay: ______ Well visit copay: _____ Co-insurance : _____ Yearly Deduct__

SECONDARY Insurance Coverage **(if Patient has 2 Insurances, Commercial Insurance is Primary and Medicaid(Assistance Insurance) is Secondary) (Process claims We need information of both Insurances and they both need to be Assigned to JULIA BARRIGA MD PA as PCP)**

Subscriber last name: _________________________________ Subscriber first name: _____________________________________

Sex: ________ Date of Birth: ________________________ Patient Relation to subscriber: ________________________________

Insurance Carrier: ____________________________________ Subscriber ID: ____

Group Number: _________________________________ Group Name: ____

Employer Name:____

Patient responsibility (If you do not know, leave it blank): PCP visit copay: ______ Well visit copay: _____ Co-insurance : _____ Yearly Deduct__